

<b>Case Number:</b>	CM15-0186553		
<b>Date Assigned:</b>	09/28/2015	<b>Date of Injury:</b>	09/14/1999
<b>Decision Date:</b>	11/10/2015	<b>UR Denial Date:</b>	09/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 58 year old female, who sustained an industrial injury on 9-14-1999, resulting in pain or injury to the neck and entire back with pain radiating into the right leg. A review of the medical records indicates that the injured worker is undergoing treatment for chronic cervical strain rule out disc herniation, chronic lumbar strain rule out disc herniation, headaches, bilateral arm overuse pain, bilateral shoulder rotator cuff syndrome, status post bilateral shoulder arthroscopies, and morbid obesity. On 8-18-2015, the injured worker reported persistent pain in the neck rated at 7 out of 10 that were noted to be frequent and worsening, and pain in the lower back rated 9 out of 10 that was frequent and worsening with radiation to her legs, walking with the assistance of a walker. The Primary Treating Physician's report dated 8-18-2015, noted the injured worker was not currently working, with the examination of the cervical spine noted to show decreased range of motion (ROM), tenderness and hypertonicity in the suboccipital region and paravertebral muscles, with positive compression test and decreased sensation in the C6 nerve distribution on the right and C7 nerve distribution bilaterally with radiation of pain into the bilateral hands. The lumbar spine examination was noted to show decreased range of motion (ROM), tenderness over the paraspinal, and decreased sensation at L5 on the right. Straight leg raise test was noted to be positive bilaterally at 60 degrees to lateral thigh as opposed to 50 degrees on the previous visit. The examination of the bilateral shoulders was noted to show decreased range of motion (ROM) and tenderness and hypertonicity bilaterally at the trapezius and parascapular musculature, with negative drop arm test and

positive bilateral supraspinatus, Neer's impingement, and Hawkin's impingement tests. Prior treatments have included chiropractic treatments, physical therapy, cervical epidural steroid injections (ESIs), lumbar epidural steroid injections (ESIs), bilateral shoulder surgeries, aquatic therapy, and medications. The Physician noted a request for authorization for a Max2 Dual-Node Percussion Massager to be used at home with home exercises to increase function and decrease pain. The request for authorization dated 9-2-2015, requested the purchase of Max 2 dual-node percussion massager. The Utilization Review (UR) dated 9-11-2015, noon-certified the request for the purchase of Max 2 dual-node percussion massager.

### **IMR ISSUES, DECISIONS AND RATIONALES**

The Final Determination was based on decisions for the disputed items/services set forth below:

**Purchase of Max 2 dual-node percussion massager:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Massage therapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Massage Therapy, Manual Therapy, Knee, Durable Medical Equipment (DME) and Other Medical Treatment Guidelines Medicare.gov, durable medical equipment.

**Decision rationale:** MTUS states regarding massage therapy, recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. MTUS and ACOEM are silent regarding the medical necessity of hand held massager. ODG does state regarding durable medical equipment (DME), recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below. Medicare details DME as: durable and can withstand repeated use-used for a medical reason, not usually useful to someone who isn't sick or injured, appropriate to be used in your home. The request massager does not meet durability criteria for DME. A massage unit would still be useful to a person who isn't sick or injured. Additionally, the purchase of a massage unit appears to indicate a number of treatments sessions in excess of the MTUS recommendations. As such, the request for Purchase of Max 2 dual-node percussion massager is not medically necessary.